

Student: _____ Grade: _____ School Year: _____
Last name First Name

Allegheny Valley School District Medication Administration Consent Form

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, each student must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian and a licensed prescriber. All medications must be in an original prescription bottle/container from a pharmacy.

Physician recommendation and order for medication administration:

Please be advised that _____ is currently under
my care for the diagnosis of _____.

Therefore it will be necessary to administer the following medication during school hours:

Name of medication:

Route and Dosage: _____

Time of administration: _____

Possible side effects:

Discontinuation date:

***This student should be permitted to carry and self-administer this medication during the school day:**
YES NO

Physician Signature

Date

Physician name printed

Physician phone number

Parent/Guardian:

Please provide this medication for my child as directed by his/her physician. I understand that a licensed medical professional will administer this medication. In the event that the nurse is not in the building, the medication will be taken in the presence of the Principal or his/her designee.

Parent Signature

Date